

Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name

: STANLEY MUIRURI WANJIRU

Card No

: I017-029-116954338-02

Policy Holder

: STANLEY MUIRURI WANJIRU

Payer Name

: ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC

TPA

: E CARE - Green Network

Validity

: 01-10-2023 To 30-09-2024

Gender

: Male

Date Of Birth

: 25-Oct-1988

Patient's Tel No

: 0569493860

Service Date

:28-Jul-2024

Health Provider

:CITICARE MEDICAL CENTER LLC

Doctor's Name

:Humaira

Co-Insurance

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Network

: Green

Direct Access SP - YES

Remarks

:

☐ Acute

☐ Pre-existing and chronic

☐ Maternity

Chief Complaints

: co epigastric pain severe 23rd july 2024 oe epigastric pain chest is clear no added sounds restless

Vitals

:Temp : 36.5 Bp :124 Pulse :68 Resp :18

Clinical Findings:

Diagnosis:

K29.70 - Gastritis, unspecified, without bleeding,R10.13 - Epigastric pain,

Date of Onset

:28/45/2024

Requested Investigations:

86677, ANTIBODY HELICOBACTER PYLORI,0005-242802-0781, PANTONIX 40MG I.V.-(PANTOPRAZOLE (AS SODIUM) : 40 MG) POWDER FOR INFUSION,96365, THER/PROPH/DIAG IV INF INIT,0005-136504-1021, SCOPINAL-(HYOSCINE : 20 MG/ML) SOLUTION FOR INJECTION,96374, THER/PROPH/DIAG INJ IV PUSH,9, Consultation GP

Estimated Cost

:

Prescriptions:

1267-141604-0082 - (ALUMINIUM HYDROXIDE : 200 MG) (MAGNESIUM HYDROXIDE : 200 MG) (SIMETHICONE : 25 MG) CHEWABLE TABLETS,0188-232401-0392 - (ESOMEPRAZOLE : 40 MG) FILM COATED TABLETS,

Estimated Cost

:

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name

: Humaira

Stamp :

Dr. Humaira Mumtaz

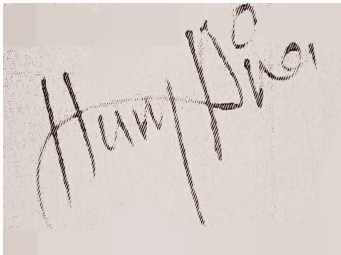
General Practitioner

DHA No: 54155530-002

CITICARE MEDICAL CENTER LLC

DUBAI - U.A.E.

Signature :



Date

: 28-Jul-2024

PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Patient 's signature{Parent : if minor}



28-Jul-2024